MONTHLY PROGRAM REPORT FOR WORK ADJUSTMENT LOA

(1) VENDOR NAME:	(2) REPORT MONTH
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Client's Name & Social Security #		Coun Dist #	Work Adjustment			STAFFING		COMMENTS	
			Date Service Began	# of hours completed in the month	Total hours attended (can't exceed 300)	Date Services Completed	Date of Staffing	Date of Staffing	

<u>Due by the 15th day of the following month</u> email to:

VRreports.DHS@tn.gov

of DRS Clients currently in Work Adjustment services _____ Cumulative total of Work Adjustment clients served this fiscal year___